



IDAHO DEPARTMENT OF
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER, GOVERNOR
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BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888

April 10, 2009

Michael Day
Independent Living Services Summerwind
P.O. Box 6395
Boise, ID 83711

RE: Independent Living Services Summerwind, provider #13G013

Dear Mr. Day:

This is to advise you of the findings of the Medicaid/Licensure survey, which was conducted at your facility, Independent Living Services Summerwind, on April 9, 2009.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no Federal deficiencies were noted at the time of the survey.

Also enclosed is a Statement of Deficiencies/Plan of Correction form listing State Licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction.

It is important that your Plan of Correction address each deficiency in the following manner:

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;
2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;
4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

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5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **April 23, 2009**, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

<http://www.healthandwelfare.idaho.gov/site/3633/default.aspx>

This request must be received by April 23, 2009. If a request for informal dispute resolution is received after April 23, 2009, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,



MATT HAUSER
Health Facility Surveyor
Non-Long Term Care



NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MH/mlw

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/10/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2009
NAME OF PROVIDER OR SUPPLIER INDEPENDENT LIVING SERVICES SUMMERWIND			STREET ADDRESS, CITY, STATE, ZIP CODE 10349 SUMMERWIND DRIVE BOISE, ID 83704		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 000	INITIAL COMMENTS Independent Living Services- Summerwind, is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation. The survey was conducted by: Matt Hauser, QMRP, Team Leader Jim Troutfetter, QMRP	W 000			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2009
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M 000	16.03.11 Initial Comments The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Matt Hauser, QMRP, Team Leader Jim Troutfetter, QMRP	M 000			
MM428	16.03.11.120.10(c) Temperature of hot water The temperature of hot water at plumbing fixtures used by the residents must be between one hundred five (105) to one hundred twenty (120) degrees Fahrenheit. This Rule is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit for 5 of 5 individuals, (Individuals #1 - #5) residing at the facility. Findings include: An environmental survey was conducted at the facility on 4/7/09 from 1:33 - 1:55 p.m., and showed the following hot water temperatures (Fahrenheit): Kitchen sink - the hot water temperature was 127.4 degrees. Bathroom in the hall - the hot water temperature was 126.6 degrees. At that time, the staff present was informed of the water temperatures. The staff present stated she was surprised at the temperatures and would correct the situation immediately. Additionally the water temperature was rechecked on 4/8/09 at 9:08 a.m. and was found	MM428	WATER TEMPERATURE WILL BE MONITORED DAILY, WATER FLOWING BEHIND TO WATER HEATER, UNTIL TEMPERATURE HAS STABILIZED FOR 1 WEEK By 4/11/09 By SUPERVISOR		

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FACILITY STANDARDS

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

D. Hauser

(X6) DATE

4/16/09

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13G013	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2009
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MM428	<p>Continued From page 1</p> <p>to be within an acceptable range.</p> <p>During an interview on 4/9/09 from 10:30 to 10:55 a.m. the Program Coordinator stated she was surprised by the high temperature and the element in the water heater had just been replaced. She further stated there was a system in place that required the water temperatures to be checked once a month.</p> <p>The facility failed to ensure hot water temperatures were maintained between 105 and 120 degrees Fahrenheit.</p>	MM428			